



IDAHO DEPARTMENT OF
HEALTH & WELFARE

JAMES E. RISCH – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N., R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

CERTIFIED MAIL: 7000 1670 0011 3314 8927

July 17, 2006

Donna Lant, Administrator
Karcher Estates
1127 Caldwell Blvd
Nampa, ID 83651

Provider #: 135110

Dear Ms. Lant:

On **June 30, 2006**, a Recertification survey was conducted at Karcher Estates by the Bureau of Facility Standards/Department of Health & Welfare to determine if your facility was in compliance with State Licensure and Federal participation requirements for nursing homes participating in the Medicare and/or Medicaid programs. This survey found that your facility was not in substantial compliance with Medicare and Medicaid program participation requirements. This survey found the most serious deficiency in your facility to be isolated deficiencies that constitute actual harm, but are not an immediate jeopardy, as evidenced by the attached CMS Form 2567L whereby significant corrections are required.

Enclosed is a Statement of Deficiencies/Plan of Correction, CMS Form 2567L, listing Medicare/Medicaid deficiencies, and a similar form listing licensure health deficiencies. In the spaces provided on the right side of each sheet, answer each deficiency and state the date when each will be completed. **Please provide ONLY ONE completion date for each Federal/State Tag in column X5 (Complete Date), to signify when you allege that each tag will be back in compliance.** After each deficiency has been answered and dated, the administrator should sign both the CMS Form 2567L and State Statement of Deficiencies, in the spaces provided, and return the originals to this office.

Your Plan of Correction (PoC) for the deficiencies must be submitted by **July 31, 2006**. Failure to submit an acceptable PoC by **July 31, 2006**, may result in the imposition of civil monetary penalties by **August 21, 2006**.

Your PoC must contain the following:

- What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice;
- How you will identify other residents having the potential to be affected by the same deficient practice and what corrective action(s) will be taken;
- What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur;
- How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place; and,
- Include dates when corrective action will be completed.

All references to federal regulatory requirements contained in this letter are found in *Title 42, Code of Federal Regulations*.

This agency is required to notify CMS Region X of the results of this survey. We are recommending that CMS impose the following remedy:

Denial of payment for new admissions effective as soon as notice requirements can be met. [42 CFR §488.417(a)]

Please note that this notice does not constitute formal notice of imposition of alternative remedies or termination of your provider agreement. Should the Centers for Medicare & Medicaid Services determine that termination or any other remedy is warranted, it will provide you with a separate formal notification of that determination.

We must recommend to the CMS Regional Office and/or State Medicaid Agency that your provider agreement be terminated on **December 30, 2006**, if substantial compliance is not achieved by that time.

If you believe these deficiencies have been corrected, you may contact Loretta Todd, R.N. or Lorene Kayser, L.S.W., Q.M.R.P., Supervisors, Long Term Care, Bureau of Facility Standards, 3232 Elder Street, PO Box 83720, Boise, ID 83720-0036, Phone #: (208) 334-6626, Fax #: (208) 364-1888, with your written credible allegation of compliance. If you choose and so indicate, the PoC may constitute your allegation of compliance.

In accordance with 42 CFR §488.331, you have one opportunity to question cited deficiencies

Donna Lant, Administrator
July 17, 2006
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through an informal dispute resolution process. To be given such an opportunity, you are required to send your written request and all required information as directed in Informational Letter #2001-10. Informational Letter #2001-10 can also be found on the Internet at:

http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10.pdf
http://www.healthandwelfare.idaho.gov/Rainbow/Documents/medical/2001_10_attach1.pdf

This request must be received by **July 31, 2006**. If your request for informal dispute resolution is received after **July 31, 2006**, the request will not be granted. An incomplete informal dispute resolution process will not delay the effective date of any enforcement action.

Thank you for the courtesies extended to us during the survey. If you have any questions, please contact us at (208) 334-6626.

Sincerely,

A handwritten signature in black ink that reads "Lorene Kayser". The signature is written in a cursive, slightly slanted style.

LORENE KAYSER, L.S.W., Q.M.R.P.
Supervisor
Long Term Care

LKK/dmj

Enclosures

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/17/2006
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2006
NAME OF PROVIDER OR SUPPLIER KARCHER ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BLVD NAMPA, ID 83651		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	<p>INITIAL COMMENTS</p> <p>The following deficiencies were cited at the annual recertification survey at your facility.</p> <p>Surveyors conducting the annual survey were:</p> <p>Kari Head, MS RDLT, Team Coordinator Betty Vivian, RN Diane Green, RN Winnie Young, RN</p> <p>Survey Definitions:</p> <p>MDS = Minimum Data Set assessment RAI = Resident Assessment Instrument RAP = Resident Assessment Protocol DON = Director of Nursing LN = Licensed Nurse RN = Registered Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record</p>	F 000	<p>RECEIVED</p> <p>JUL 31 2006</p> <p>FACILITY STANDARDS</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Donna L. Lant *Executive Director* *7/31/06*

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 153 SS=C	<p>483.10(b)(2) NOTICE OF RIGHTS AND SERVICES</p> <p>The resident or his or her legal representative has the right upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and after receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of the facility admission packet and staff interview, it was determined the facility did not ensure residents were correctly informed of their rights to access their medical records. This had the potential to affect all resident's admitted to the facility. Findings include:</p> <p>The information provided to residents upon admission to the facility was reviewed on 6/28/06 at 10:00 am. Page 16 of the facility's "Health Care Admission Agreement" documented, "The resident or legal representative has the right, upon oral or written request, to access all records pertaining to himself or herself..." Upon further review of the packet, another form, titled, "Omnicare, Inc. and Affiliated Entities Notice of Privacy Practices" documented, "Right to Inspect and Copy: You have the right to inspect and/or obtain a copy of the health information about you that we maintain in certain groups of records that are used to make decisions about your care. Your request must be in writing..." These two forms presented conflicting</p>	F 153	<p>F 153</p> <p>-THE FORM IDENTIFIED IN THIS F TAG IS NO LONGER IN KARCHER ESTATES ADMIT PACKET.</p> <p>-THIS FORM WILL BE SENT TO NEW RESIDENTS BY OUR PHARMACY.</p> <p>-WE WILL NO LONGER HAVE ANYTHING TO DO WITH THIS FORM.</p> <p>-COMPLETION 7/31/2006</p> <p>Per telephone 8/4/06</p>		
			<p>adm & Don:</p> <p>1. Letters were sent to all Residents and/or families explaining incorrect information</p>		

2. Staff were in service
3. Marketing Person will monitor for compliance

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F 153	Continued From page 2 information on a resident's rights related to access to medical information. On 6/28/06 at 10:30 am, the DON was interviewed and acknowledged the two forms presented conflicting information and that residents had the right to access their records by either a verbal or a written request. At this time, the DON indicated the Omnicare form was related to the contracted pharmacy the facility used and was referring to the pharmacy records that are maintained at the corporate offices and did not pertain to the resident's medical record while at the facility. The DON acknowledged that the Omnicare form did not clearly indicate what records the form was referring to and agreed it could cause confusion as to how a resident could access their records.	F 153			

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F 225 SS=D	<p>483.13(c)(1)(ii)-(iii), (c)(2) - (4) STAFF TREATMENT OF RESIDENTS</p> <p>The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities.</p> <p>The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced</p>	F 225	<p>F 225</p> <p>-ANY INCIDENT OF UNKNOWN ORIGIN INVOLVING #13 WILL BE INVESTIGATED IMMEDIATELY AND ALL STAFF INVOLVED WILL BE INTERVIEWED TO ATTEMPT TO DETERMINE HOW INCIDENT MAY HAVE OCCURRED.</p> <p>-ALL INCIDENTS OF UNKNOWN ORIGIN WILL BE INVESTIGATED; INTERVIEWS WILL BEGIN IMMEDIATELY BY LICENSED STAFF.</p> <p>-ALL LICENSED STAFF WILL BE INSERVICED REGARDING EXPECTATIONS AND RESPONSIBILITIES.</p> <p>-INCIDENTS WILL BE REVIEWED BY UNIT MANAGERS AND DON.</p> <p>-COMPLETION 7/31/2006</p>		

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F 225	Continued From page 4 by: Based on record review and staff interview, it was determined the facility did not thoroughly investigate injuries of unknown origins to rule out the possibility of abuse. This was true for 1 of 15 sampled residents (#13). Findings include: Resident #13 was admitted to the facility on 5/5/06 with the diagnoses of pulmonary embolism, diabetes mellitus, congestive heart failure, cardiovascular disease, weakness, and an unspecified head injury. On 5/30/06 an Incident Data Questionnaire documented the resident had received a "skin tear." This report indicated the incident happened on the night shift. Under the Skin Related Injury section of this report it was documented, "How did it happen? Unknown. Who was it allegedly caused by? Unknown. What was it allegedly caused by? Unknown. Was there an investigation? Yes. What did the investigation reveal? [no] rough edges." This investigation did not include interviews with staff to determine how the skin tear occurred and to rule out abuse. On 5/31/06, another Incident Data Questionnaire documented the resident had been found with "Busing [with] a blood blister the size of a dime on lower area." The time and location of the incident was documented as "unknown." Under the Skin Related Injury section was documented, "Bruising to rt [right] lower posterior calf. How did it happen? Unsure probably during self transfer. Who was it allegedly caused by? patient. What was it allegedly caused by? w/c [wheelchair] foot rest, probably. Was there an investigation? Blank. What did the investigation reveal? Blank." This	F 225			

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F 225	Continued From page 5 investigation did not include interviews with staff to determine how the bruising occurred to rule out abuse. This investigation also left some key areas blank. This investigation was not thorough. On 6/15/06, another Incident Data Questionnaire documented the resident indicated "her arm hurt. Skin tear on L [left] elbow found." Under the Skin Related Injury section was documented, "How did it happen? Not sure - resident doesn't know either. Who was it allegedly caused by? Not sure. What was it allegedly caused by? Not sure. Was there and investigation? Blank. What did the investigation reveal? Blank." This investigation did not include interviews with staff to determine how the skin tear occurred to rule out abuse. This investigation also left some key areas blank. This investigation was not thorough. On 6/29/06 at 11:50 am, the DON was interviewed and acknowledged that the above investigations into injuries of unknown origin were not complete and thorough to rule out abuse.	F 225			
F 241 SS=D	483.15(a) DIGNITY The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.	F 241			
	This REQUIREMENT is not met as evidenced by: Based on record review, observation and staff interview, it was determined the facility did not ensure each resident's dignity was maintained				

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F 241	Continued From page 6 when staff failed to pull the privacy curtain and close blinds on a window to the outside during the provision of personal care. The facility also did not ensure the dignity of a resident was encouraged when staff got the resident up very early to sit and wait out by the nurses station until breakfast. This was true for 1 of 15 sampled residents (#8). Findings include: 1. Resident #8 was admitted to the facility on 11/12/02 with the diagnoses of dementia, right bundle branch block, cardiovascular disease, hypothyroidism, and depression. The resident's most recent quarterly MDS, dated 4/13/06, documented the resident was severely cognitively impaired and was totally dependent on one to two staff for all activities of daily living. a) On 6/27/06 at 1:22 pm, resident #8 was assisted to bed by 2 CNAs. Both CNA 1 and CNA 2 transferred the resident to her bed using a Hoyer type mechanical lift. At this time the resident's roommate was sitting in her recliner directly to the right of resident #8's bed. The CNAs transferred the resident to the bed using the lift. There was a window to the left of the foot of the resident's bed. The vertical blinds were drawn, but not closed and visible to the outside. CNA 1 and CNA 2 lifted the resident's gown to her abdomen exposing the resident's adult briefs. The CNAs then checked the resident for incontinence but was found to be dry. The CNAs then pulled the resident's gown down and covered her with a blanket after positioning her for comfort. Although the CNAs did not change the resident's briefs, they did expose the resident's briefs to the resident's roommate and potentially to anyone passing by the resident's window. The	F 241	F 241 -RESIDENT #8 HAS HAD HER WINDOW COVERING AND PRIVACY CURTAINS CLOSED DURING CARES SINCE THE SURVEY. SHE WILL BE SHOWERED PRIOR TO BREAKFAST AS IDENTIFIED BY FAMILY AS WAS HER PREFERENCE. SHE IS END STAGE DEMENTIA AND SLEEPS THE ENTIRE DAY EXCEPT DURING MEALS AND SHOWERS. WE WILL NOT SHOWER HER PRIOR TO 7:00AM. -ALL RESIDENTS WILL BE ASKED BY SOCIAL SERVICES WHEN THEY PREFER TO GET UP AND WHEN THEY PREFER TO BE BATHED. STAFF WILL ACCOMMODATE RESIDENT WISHES AS BEST AS POSSIBLE. STAFF WILL PULL CURTAINS AND CLOSE BLINDS DURING CARES FOR ALL RESIDENTS.		

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F 241	<p>Continued From page 7</p> <p>CNAs did not protect the resident's privacy and dignity when they neglected to pull the privacy curtain and shut the blinds.</p> <p>On 6/28/06 at 1:30 pm, the DON and administrator were informed of the above observation and agreed the privacy curtain between the resident and her roommate should have been pulled, as well as the blinds completely closed, to protect the resident's dignity during the provision of cares.</p> <p>b) On 6/28/06 at 5:45 am, resident #8 was not in her room. A CNA was in the room stripping the resident's bed and making it with clean linen. The CNA was asked where the resident was and the CNA indicated she was in the shower. At 6:00 am, the resident was taken from the shower to her room where she was transferred to bed. While waiting for the mechanical lift, the surveyor asked the CNA if this was the time the resident usually got up. The CNA replied "on her bath day she gets up at this time. I don't know about the other days." The resident was then transferred into bed, dressed and then transferred back into her Geri Chair. The resident was then wheeled to the nurses station to sit until 7:45 am. During this time she was observed to sleep while in the Geri Chair. At 7:45 am, resident #8 was taken to the dining room to wait for breakfast.</p> <p>On 6/28/06 at 1:30 pm, the DON and administrator were informed of the resident being woken up early to shower and made to sit and sleep out by the nurses station. They both agreed the resident could have been allowed to rest more comfortably in her bed until breakfast and did not have to get up so early in order to get a bath.</p>	F 241	<p>-ALL NURSING STAFF WILL BE INSERVICED REGARDING PRIVACY AND ACCOMODATION OF NEEDS. -SDC AND UNIT MANAGERS WILL MAKE RANDOM ROUNDS FOR COMPLIANCE. -COMPLETION 7/31/2006</p> <p><i>Per phone conversation 8/4/06 w adm & Don Mgrs will make monthly Rounds & document</i></p>		

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F 242 SS=D	<p>483.15(b) SELF-DETERMINATION AND PARTICIPATION</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on resident and staff interview it was determined residents were not always included in decisions regarding schedules and able to make choices that were significant to the resident. This was the case for 2 of 5 sample residents (#2, 4) reviewed who were able to be included in decisions and able to make choices about the time they wanted to get up in the morning. Findings include:</p> <p>1. Resident #2 was admitted to the facility on 4/27/06 with diagnoses of Parkinson disease, status post pneumonia and depression.</p> <p>The admission MDS, dated 5/09/06, indicated the resident was independent in decision making.</p> <p>On 6/26/06 at 2:55 pm the resident was observed and interviewed in her room while she sat in a chair at the bedside. She stated, "I get so tired when I get up so early." She stated she gets up at 6:00 am and waits for breakfast until 8:00 am.</p>	F 242	<p>F 242</p> <p>-RESIDENT #2 &4 ARE GETTING UP WHEN THEY CHOOSE.</p> <p>-ALL RESIDENTS WILL BE ASKED BY SOCIAL SERVICES WHEN THEY PREFER TO GET UP. THIS WILL BE DOCUMENTED IN THE SOCIAL SERVICE NOTES AND ON EACH CARE PLAN.</p> <p>-ALL STAFF WILL BE INSERVICED REGARDING RESIDENTS RIGHT TO CHOOSE WAKE UP TIMES AND SHOWER TIMES. ALL STAFF WILL BE MADE AWARE OF SPECIFIC CHOICES OF RESIDENTS.</p> <p>-RANDOM ROUNDS WILL BE DONE BY UNIT MANAGERS, SDC AND SOCIAL SERVICE DIRECTOR FOR COMPLIANCE.</p> <p>-COMPLETION 7/31/2006</p>		

*Per phone conversation
8/4/06 w adm & Don
monthly rounds will be
done & documented*

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F 242	<p>Continued From page 9</p> <p>On 6/27/06 the resident was observed in the dining room at 7:45 am. She stated she had a shower before breakfast.</p> <p>On 6/28/06 at 6:00 am the resident was observed to be sleeping. At 6:30 am the restorative CNA came into the room, woke the resident, and told her to start dressing to see how much she could do for herself. She dressed herself with the assistance of the CNA by 7:30 am and then was taken to the dining room.</p> <p>On 6/28/06 at 8:30 am the resident was observed in her room. She stated she was tired and did not like to get up early.</p> <p>On 6/28/06 at approximately 1:00 pm the Administrator and DON were informed of the residents desire to sleep later in the morning. On 6/29/06 at 7:30 am the resident was observed to be asleep in her bed.</p> <p>2. Resident #4 was admitted to the facility on 10/10/03 with diagnoses that included senile dementia and depressive disorder, diabetes, and ABK [above the knee] amputee. The quarterly MDS assessment dated 4/2/06, documented he was totally dependent on staff for transfer, toileting and bathing.</p> <p>On 6/28/06 at 6:03 am, the surveyor accompanied 2 CNA's into resident #4's room.</p>	F 242			
	<p>One CNA approached the resident, leaned over him and said, "Time to get up, wake up, we're going to get you ready for breakfast." The resident was observed to slowly open his eyes and look at the CNA. The CNAs continued with the residents morning cares. When they were</p>				

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F 242	Continued From page 10 finished they transferred him to his wheelchair and rolled him out into the hall. The surveyor asked the resident, "Do you like getting up this early?" He stated, "No". The resident was observed in the hall during the next hour and a half, dozing. The resident went to the dining room and was served his breakfast at 8:00 am.	F 242			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING/MAINTENANCE The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview it was determined that the facility did not maintain a clean and sanitary bathing area for 1 of 5 sampled residents, who resided on the 'B' hall. The findings include: On 6/27/06 at 7:50 am, resident #7 was observed showering in a bathing area where spots and long strips of wax and dirt buildup of a dark brownish/yellow color were found along the walls (approximately 4 - 5 feet in length). The same dark brownish/yellow coloring was found along the floors near the walls in the adjacent bathroom, tub room, across from the shower, and in the dressing area. The shower room floor had a non-skid covering that was peeling and hanging loose in one corner. The peeling area was about the size of a grapefruit.	F 253			

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F 253	Continued From page 11 The entire dressing/bathing area was not well ventilated. It was very hot and humid and it was observed that 2 ceiling fans were not working properly. On 6/27/06 at 8:15 am the DON and the Administrator stated they were unaware the bathing area was not clean.	F 253	<p>F 253</p> <p>-SHOWER FLOOR WILL BE REPLACED WITH ANOTHER NON-SKID TYPE COVERING. SEE WORK ORDER FOR DATE IT WILL BEGIN.</p> <p>-THE FLOOR SURROUNDING THE SHOWER WILL BE REPLACED WITH NON-SKID TILES. SEE WORK ORDER FOR DATE WORK WILL BEGIN.</p> <p>-DURING SURVEY MAINTENANCE STAFF WERE NOT ASKED QUESTIONS REGARDING THE CEILING FANS. CEILING FAN WAS OPERATIONAL DURING SURVEY. THE OTHER VENT IS AN AIR CONDITIONING VENT WHICH WAS ALSO OPERATIONAL. THE CEILING FAN WAS CLEANED DURING SURVEY AND</p> <p>CONTINUES TO BE OPERATIONAL.</p> <p>-MAINTENANCE DEPARTMENT WILL MONITOR DURING WEEKLY ROUNDS.</p> <p>-COMPLETION 7/31/2006</p>		

Per phone conversation 8/4/06
adm + don. The non skid
flooring replaced. Called +
discussed the "yellow" floor +
super. OK to do 8/14/06

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F 278 SS=E	<p>483.20(g) - (j) RESIDENT ASSESSMENT</p> <p>The assessment must accurately reflect the resident's status.</p> <p>A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.</p> <p>A registered nurse must sign and certify that the assessment is completed.</p> <p>Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.</p> <p>Under Medicare and Medicaid, an individual who willfully and knowingly certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or an individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$5,000 for each assessment.</p> <p>Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is not met as evidenced by:</p>	F 278			
	Based on record review and staff interview it was determined the facility did not ensure that each resident's cognition status was accurately coded on the MDS assessment. Also, the facility did not ensure pressure relieving devices were correctly coded on the MDS assessment. This was true for 8 of 15 sampled residents (#1, #2, #4, #5, #10,				

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F 278	<p>Continued From page 13</p> <p>#11, #12, and #13). The findings include:</p> <p>1. Resident #12 was admitted to the facility on 5/18/06 with diagnoses of dementia and osteoporosis.</p> <p>The MDS, Medicare 30 day assessment, dated 6/23/06, indicated that the resident's cognitive level was independent with some difficulty in new situations.</p> <p>The care plan, dated 6/01/06, indicated that on Problem 8, resident has "alteration in thought process - cog (cognitive) deficit r/t (related to) dx (diagnosis) of progressive dementia."</p> <p>On 6/06/06 at 10:35 the nurses notes indicated that, "Res (resident) alert with confusion." On 6/12/06 at 2:45, the notes indicated the resident was "Confused and alert." On 6/19/06, 2100 (11:00 pm), nurses notes indicated the following, "Poor safety awareness, confusion. Tried to undo w/c (wheelchair) belt - alarms sounding - would sit back and immediately try to get out of w/c. Found wandering down hall, gait unsteady." On 6/24/06 at 1700 (5:00 pm), the notes indicated, "Very confused, agitated with lap belt alarm. Numerous attempts to stand up and undo belt."</p> <p>The medical records indicated that the resident was being given Risperdal (a psychoactive drug for agitated behavior) 0.25 mg (milligrams) po (by mouth) q (every) day at 1700 (5 pm). Resident #12 was also given Aricept (to improve cognition) 5 mg q HS (at night).</p> <p>On 6/29/06, during a family interview with Resident #12's wife, it was stated, "He was up all</p>	F 278	<p>F 278</p> <p>-ALL RESIDENTS CITED WHO HAVE BEEN CODED INCORRECTLY IN THE AREA OF COGNITION WILL BE REVIEWED DURING THE NEXT QUARTERLY REVIEW OF THE MDS AND WILL BE CODED ACCORDING TO THE RAI MANUAL GUIDELINES/DEFINITION</p> <p>RESIDENT #1 HAS A PRESSURE REDUCING PAD IN WHEELCHAIR AND MATTRESS ON HER BED. KARCHER ESTATES DOES NOT HAVE ANYTHING OTHER THAN PRESSURE REDUCING/PRESSURE RELEIVING PRODUCTS FOR MATTRESSES AND WHEELCHAIR PADS.(SEE INFORMATION).THERE WAS NO INCORRECT CODING ON THE MDS.</p> <p>-STAFF RESPONSIBLE FOR MDS CODING WILL REVIEW THE RAI MANUAL IN THE AREAS OF CONCERN.</p> <p>-DON AND OUTSIDE AUDITORS WILL DO RANDOM AUDITS OF SECTION B AND P.</p> <p>-COMPLETION 7/31/2006.</p>		

Per phone conversation 8/4/06
Supervision OK - This POC
MDS coder had documented
update training on RAI coding

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F 278	Continued From page 14 night at home and so was I. It seems he was having memory problems lately, too." The facility did not ensure the resident's cognitive status was accurately coded. 2. Resident #4 was admitted to the facility on 10/10/03 with diagnoses that included senile dementia and depressive disorder. The quarterly MDS assessment, dated 4/2/06 section B4 documented, "Cognitive skills for daily decision making - 0. Independent - decisions consistent/reasonable." The annual MDS assessment dated, 10/7/05 section B2, documented "Memory - 1. Memory problem. - section B4, documented Cognitive skills for daily decision making - 0. Independent." The RAP summary dated 10/3/06 triggered for Cognitive Loss/Dementia due to alteration in thought process - memory deficit and impaired decision making related to a diagnosis of vascular dementia with depression. A social service admission note dated 10/15/03 indicated the family was very involved to help make decisions for the resident because his dementia was worsening.	F 278			
	A nurses note dated 4/04/06, "He continues to need a self-releasing seat belt alarm & bed alarm because of poor safety awareness." A nurses note date 4/15/06, "Pt.[patient] hallucinating tonight - came out of dining room				

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F 278	Continued From page 15 saying 'get that squirrel over there' and pointing to the hand rail in hall." 3. Resident #5 was admitted to the facility 12/12/00 with diagnoses that included senile dementia, convulsions and depressive disorder. The annual MDS assessment dated 10/05/06 indicated that the resident was independent for cognitive skills. B4 was recorded - 0. "Makes decisions consistent and reasonable." The RAP summary dated 10/05/06 triggered for cognitive loss and dementia. The care plan dated 10/05/06 documented, "Resident has alteration in thought process with memory deficit related to dementia." A social service note dated 9/30/05 documented, "Annual assessment. Cont.[inues] with a memory deficit - possible r/t [related to] some hearing difficulty...Often focuses on single issues and not able/willing to move to other issues...Noted attempts to save money by not changing attends when needed. Noted to be rude at times..." 4. Resident #11 was admitted to the facility with diagnoses that included dementia, Alzheimer's disease and psychosis. The initial MDS assessment dated 3/15/06 indicated that the resident was independent for cognitive skills. B4 was recorded a 0. "Makes decisions consistent and reasonable. The RAP summary dated 3/15/06 triggered for cognitive loss/dementia. Summary statement, "Noted dx [diagnosis] dementia, Alz[heimer's] type; will care plan." On 6/28/06 at approximately 2:30 pm, during an interview with the South A LN Care Coordinator and the LSW Social Service Coordinator the LN acknowledged that she would not assess resident	F 278			

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F 278	Continued From page 16 #4 as a 0 in cognition. The LSW disagreed and stated, "I see them in the halls wheeling them self in their wheelchairs. They decide where they want to go and can tell you what they want to do." 5. Resident #2 was admitted to the facility on 4/27/06 with diagnoses of Parkinsons disease and depression. The admission MDS, dated 5/09/06, indicated that Resident #2 was independent and made decisions that were reasonable and consistent. Social Service Progress notes of 5/02/06 indicated the following: "Also states she is experiencing hallucinations at times - hears and sees things that are not there. No evidence that she is acting on these hallucinations." The Nurses notes of 5/23/06 at 10:30 stated "Alert and mild confusion this am." Again on 5/24/06 at 10:30, the notes indicated, "Alert with mild confusion." The facility did not ensure the resident's cognitive status was accurately coded. There were similar findings for resident #'s 1 and 13 who were inappropriately assessed as independent with cognitive skills for daily decision making.	F 278			
	6. Resident # 1 was readmitted to the facility on 10/13/05 with the diagnoses of dementia, diabetes mellitus, cerebral vascular accident, chronic obstructive pulmonary disease, pneumonia, hypertension and osteoporosis. The resident's last two quarterly MDS assessments,				

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F 278	<p>Continued From page 17</p> <p>dated 1/24/06 and 4/24/06, both documented the resident had pressure relieving devices in the bed and wheelchair.</p> <p>The resident's Interdisciplinary Progress Notes documented on 12/21/05 at 2:00 pm, "Removed air overlay and placed raised-edge mattress. She is in a low bed also and will need a floor mat also."</p> <p>On 6/26/06 at 2:15 pm, resident #1 was observed lying in bed. There was no cushion in her wheelchair. The resident was on a low bed with a lip mattress. This mattress was not an air bed or an air overlay. It appeared to be a regular mattress.</p> <p>On 6/27/06 at 8:38 am, resident #1 was observed sitting in her wheelchair out by the nurse's station. There was no cushion observed in her wheelchair. At 11:17 am, resident #1 was observed lying in bed.</p> <p>On 6/28/06 at 6:45 am, resident #1 was observed sitting in her wheelchair. The resident did not have a pressure reducing device in her chair.</p> <p>On 6/29/06 at 9:29 am, resident #1 was observed in her wheelchair sitting by the nurse's station. There was no pressure relieving device in her wheelchair.</p>	F 278			
	<p>On 6/29/06 at 11:10 am the unit manager was interviewed. She acknowledged that the resident was supposed to have a pressure relieving device in her wheelchair but indicated the one they had for the resident caused some positioning concerns at times. The unit manager indicated</p>				

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F 278	Continued From page 18 they were working on getting her one that worked better. On 6/29/06 at 11:50 am, the DON was interviewed and was informed of the resident not having a pressure relieving device in her bed or wheelchair during survey. The DON did not know if the resident's lip mattress was pressure relieving or reducing but though it was at least a reduction in pressure. The DON was asked to provide the manufactures information related to pressure reduction for that specific mattress. No information was provided.	F 278			

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F 280 SS=E	<p>483.20(d)(3), 483.10(k)(2) COMPREHENSIVE CARE PLANS</p> <p>The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility failed to ensure resident's comprehensive care plan were periodically reviewed and revised to meet their needs. This was true for 5 of 15 sampled residents (#'s 1, 4, 7, 10, and 13) whose care plans were reviewed for accuracy. Findings include:</p>	F 280			
	<p>1. Resident #4 was admitted to the facility on 10/10/03 with diagnoses that included diabetes type 1 and above knee amputation of right leg due to osteomyelitis. The annual MDS assessment dated 9/28/05 indicated the resident was totally dependent with two+ persons physical</p>				

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F 280	Continued From page 20 assist for transfer, dressing and toilet use and needed extensive assistance of one person for bed mobility. MDS Section J: Health Conditions - 1. Problem Conditions documented, "edema". MDS Section M: Skin Condition - 1. Number of Ulcers documented, "a. Stage I - 2" This indicated that it was a pressure ulcer. The most recent quarterly MDS assessment, dated 4/2/06, recorded the same status as above. The Care Plan dated 4//02/06, included the following: a) "Problem: Alteration in mobility R/T [related to] RT [right] BKA [below the knee ambulation], dementia, M/B [manifested by] non-ambulatory, assist with bed mobility and transfer. Approach(s) - - Assist to reposition. Turn q 2 hr [hour] in bed. Pressure alarm in bed due to dementia with impulsivity. Self-release seat belt alarm in w/c [wheelchair]. Raised edge mattress in bed. Sabina Lift [sit to stand]." b) "Problem: Potential for alteration in skin integrity R/T dementia, RT bka, IDDM [insulin dependent diabetes mellitus] incont[inent] with cognitive and physical losses. Approach(s) - Weekly skin assessment on bath day. 1 person assist to reposition q 2 hr...pressure reducing mattress on bed and pad in w/c. Total assist with incont[inece] management...puff-boot to LLE in bed to reduce pressure and shearing of LT heel, Ted hose, no shoes.	F 280	F 280 -RESIDENTS #1,4,7,13 HAD THEIR CARE PLANS CORRECTED DURING THE SURVEY. -ALL RESIDENTS WILL HAVE THEIR CARE PLANS REVIEWED DURING QUARTERLY REVIEWS AND CHANGES WILL BE MADE WHEN CARE NEEDS CHANGE. -ALL LICENSED STAFF WILL BE INSERVICED REGARDING NEED TO HAVE CARE PLANS REFLECT CURRENT CARE NEEDS. -RANDOM AUDITS BY UNIT MANAGERS AND DON WILL BE DONE. -COMPLETION 7/31/2006		
	On 6/26/06 at 2:00 pm, resident #4 was observed in bed. He was on his back and his eyes were closed. He was covered with a small quilt. His mattress was observed to be a concave lip mattress with no pressure relief. His left foot was not visible to the surveyor.				

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F 280	<p>Continued From page 21</p> <p>On 6/26/06 at 3:00 pm, the resident was observed in bed, his eyes were closed. His left leg was bent at the knee and his foot was resting on the surface of the bed. His quilt was slightly hanging off the right side of the bed allowing visibility of his left foot. He was observed wearing a light weight non-pressure relieving blue puff boot on his left foot.</p> <p>On 6/28/06 at 6:03 am, during the resident's morning cares he was observed wearing the soft puff boot on his left foot. After cares he was transferred to his wheelchair and the CNA put on a black shoe on the resident's left foot. When asked about the shoe the CNA indicated he wore a diabetic shoe when he was up in his wheelchair.</p> <p>On 6/29/06 at approximately 2:00 pm, during an interview with the South A Care Coordinator, she acknowledged that resident #4 had been fitted with a diabetic shoe in April 2006. Documentation from the company was presented to the surveyor for review.</p> <p>Although the resident had been fitted for a diabetic shoe in April 2006 the care plan was not updated to reflect the new shoe. There were no interventions documented in the care plan to direct the staff on the care of the resident's foot. (i.e. check foot for proper fit, check for edema that might be caused by the shoe, how long was he allowed to have his leg and foot in a dependent position, and how long he was to wear the shoe.)</p> <p>2. Resident #1 was readmitted to the facility on 10/13/05 with the diagnoses of dementia,</p>	F 280			

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F 280	<p>Continued From page 22</p> <p>diabetes mellitus, cerebral vascular accident, chronic obstructive pulmonary disease, pneumonia, hypertension and osteoporosis.</p> <p>The resident's most current care plan, dated 4/13/06, documented the following related to skin integrity approaches, "Apply heel and elbow guards as necessary, FYI [for your information]: will not leave on, Pressure relieving mattress on bed [and] cushion in w/c, report any red or open areas, SAR checks weekly on bath day..."</p> <p>On 6/15/06, the resident's Interdisciplinary Progress Notes contained an entry that documented, "(Callous) Left heel [with] area that is open. Entire area 1.5 x [by] 1 cm [centimeters] raw appearing - Center 0.6 x 0.3 cm open/scabbed area.</p> <p>A facsimile was found to the resident's physician, dated 6/15/06, which documented "Open area on lt [left] heel. 1.5 x 1 cm [with] open area 0.6 x 0.3. [no] drainage. May we clean [with] wound cleanser [and] cover [with] hydrosorb [and] Mefix tape q d [day] till healed. Also may we give MVI [multivitamin] - Vit C 500 mg [milligram] BID [twice a day] [and] Zinc 220 mg q d to promote wound healing?" They physician responded on 6/19/06 and indicated, "yes" to the above request.</p> <p>The resident's care plan documented an update on 6/15/06 under the skin integrity section and indicated, "left heel open area - (old callous) see tx [treatment] sheet." This care plan update did not indicate the resident was to have the heels floated or than any other special device to the foot/heel was applied to reduce/relieve pressure..</p>	F 280			

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F 280	<p>Continued From page 23</p> <p>Resident #1's Interdisciplinary Progress Notes documented the following after identifying the wound;</p> <p>*6/16/06, "...puff boots in place while in bed."</p> <p>*6/18/06, "...dressings changed on lt forearm [and] lt heel. No s/s [signs or symptoms] of infection. Puff boot in place when in bed.</p> <p>*6/19/06, "...Left heel dressing [changed] [with] hydroabsorb [after] being cleaned [with] ns [normal saline]. Area about 1/2 cm in diameter. Puff boot in place on [left] lower extremity..."</p> <p>*6/22/06, "Calloused area on L outer heel is dry and not open. There is a dark spot in the middle which is a dry scabbed area. She is using a puffboat {sic} while in bed and on Vit C [and] Zinc [and] MVI. Skin protocol in process and area is looking better. The [illegible word] isn't draining or red or mushy or painful."</p> <p>Resident #1's care plan had not been updated to include the use of an "air puffboot," as noted in the interdisciplinary notes. There was no indication on the care plan or in any treatment sheets that directed when the boot was to be on or gave any direction to float the other heel.</p> <p>3. Resident #13 was admitted to the facility on 5/5/06 with the diagnoses of pulmonary embolism, diabetes mellitus, congestive heart failure, cardiovascular disease, weakness, and an unspecified head injury.</p>	F 280			
	<p>The resident's "Physician Recapitulation Orders" for June 2006, documented an order for "Bilateral knee high ted hose - on in AM/Off [at] HS [hour of sleep]. May use thigh high. Dx [diagnosis]: edema." The origination date of this order was 5/10/06.</p>				

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F 280	<p>Continued From page 24</p> <p>Resident #13's Comprehensive Care Plan, dated 5/9/06, documented "Ted hose on in am and off at hs."</p> <p>Resident #13 was observed on 6/28/06 at 12:05 pm and on 6/29/06 at 8:55 and 9:18 am. At each observation the resident did not have ted hose on either of her legs.</p> <p>On 6/29/06 at 11:50 am, the DON was interviewed related to ted hose not being on this resident. At that time she did not know why they were not on, but agreed to look into it and get back to the surveyor. At approximately 1:00 pm, the DON and a LN stopped the surveyor in the hall and indicated the resident did not have ted hose on because resident #13 would take them off as soon as they [the staff] put them on. The DON and LN acknowledged the resident's care plan was not updated to include the refusal to wear ted hose.</p> <p>4. Resident #7 was admitted 5/27/04 with diagnoses that included post cerebral aneurysm rupture with significant infarct and resultant dysarthria and ataxia. The annual MDS assessment, dated 4/17/06, indicated the resident was independent in decision making and was totally dependent for ADL's. The assessment indicated the resident had limitations of range of motion of the arms hands, legs and feet bilaterally.</p>	F 280			
	<p>The care plan dated, 4/20/06 documented, "Has special seating system ... observe for good body alignment and position for comfort."</p>				

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F 280	<p>Continued From page 25</p> <p>On 6/27/06 at 12:15 pm prior to and during lunch in the dining room the resident was observed in her wheelchair. Her wheelchair had no lateral positioning devices. The resident's head and upper torso were leaning sharply to the left. At 12:25 pm, a CNA was asked about the special seating system the resident used. She stated she had worked at the facility for a year and had never seen anything in the resident's wheel chair to help her sit upright. The CNA assisted the resident to eat and did not reposition the resident to maintain her in a midline position.</p> <p>On 6/27/06, at 8:50 am, during an interview, the physical therapist indicated a wheelchair was being modified for the resident, however it was a used chair and some parts needed repair. Before the chair was completed however, it had been decided the modified chair would not be appropriate for the resident. The resident liked to wheel her own chair and she would not be able to do so in the modified chair. He was not aware of any other positioning devices to assist the resident to maintain body alignment in the wheelchair. He stated he thought the resident had lateral supports in her wheelchair for positioning at one time but the supports caused skin problems under her arms from leaning to the left.</p> <p>The following observations were made during the survey:</p>	F 280			
	<p>On 6/26/06 at 10:50 am the resident was observed in a wheelchair by the bed sleeping. She was leaning sharply to the left with the top left of her body leaning over the wheel of the chair.</p>				

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F 280	Continued From page 26 On 6/26/06 at 7:30 am the resident was observed in the shower room in a shower chair. The CNA had just completed her bath. Two CNA's helped the resident stand, holding on to a grab bar in the shower area and transferred her into the wheelchair. She was leaning sharply to the left and that is how she was seated in the chair. She was not repositioned before leaving the bathing area. On 6/27/06 at 9:30 am she was observed in activities leaning sharply to the left side in her wheelchair. On 6/27/06 at 12:15 pm she was observed in the dining room leaning sharply to the left in her wheelchair. On 6/27/06 at 1:00 pm she was observed outside of the dining room in the hallway leaning sharply to the left in her wheelchair. On 6/27/06 at 1:30 pm the LN was asked about the resident's body alignment in the chair. She indicated staff did not use any supports to maintain position or change the resident from the wheelchair to a recliner to improve body alignment. On 6/19/06 the care plan indicated, "change to mechanical lift."	F 280			
	On 6/26/06 at 3:00 pm the resident told the surveyor and DON that she did not have a problem with the lift but she did not feel she needed it.				

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F 280	<p>Continued From page 27</p> <p>On 6/27/06 at 7:45 am the resident was observed in the shower room transferred from the shower chair to the wheelchair by 2 CNA's. A mechanical lift was not used.</p> <p>On 6/28/06 at 7:35 am a CNA came into the resident's room with a lift with a full body sling. The resident stated, "I do not use that lift." The CNA stated, "I have not taken care of the resident since she was put on a lift. I am not sure what lift she uses but I will go and check." At that time the DON came into the room and reminded the resident she needed to, "use a lift so she would not hurt the girls back." The resident stated, "I do not want to hurt the staff, but that is not the lift I use and I need to get to the bathroom right away." At 7:45 am the CNA returned with the standing lift and transferred the resident to the bathroom. The resident stated that staff during the day shift usually knew how to use the lift but not staff in the afternoon.</p> <p>The care plan did not provide specific directions regarding the type of mechanical lift to use and the approach to use if the resident refused the use of the lift.</p> <p>5. Resident #10 was admitted to the facility on 3/22/06, with diagnoses that included, left below the knee amputation, peripheral vascular disease, and cardio vascular attack. The MDS readmission assessment for 3/26/06, indicated that the resident was independent for daily decision making, and was a totally dependent transfer for activities of daily living.</p> <p>The care plan, dated 4/06/06, indicated the use of a mechanical lift for transfers but did not identify</p>	F 280			

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F 280	Continued From page 28 the type of lift to be used or the safety precautions to be used with the use of the lift. The care plan, dated 4/4/06, indicated the resident had been identified as having an "alteration in skin integrity." An undated entry documented, "Air overlay," another care plan entry, dated 5/10/06, documented, "DC'd [air overlay] per resident request." Report any red or open areas, SAR [skin at risk] weekly on bath day. Skin breakdown will not progress from stage 1 to stage II in 30-90 days, Drsg [dressing] changes as ordered for pressure ulcer on coccyx..., position resident off of affected area on coccyx." The care plan indicated the resident had a pressure sore on 4/4/06. Interdisciplinary notes, dated 3/27/06, documented, "Res [resident] c/o [complained] pain in "tail bone", "butt" region while sitting in the wheelchair during therapy. She stated, "You cannot believe how bad my butt hurts to sit in this chair." Nsg [nursing] notified so can assess." There was no assessment located in the record. Interdisciplinary notes, dated 4/6/06, documented, "Admitted with stage II, is healing." There was no description of the wound. Interdisciplinary notes, dated 5/10/06 at 10:40 am, documented, "[resident] requests the air overlay be removed, coccyx wound in healing stage." That same day at 9:00 pm a note documented, "c/o of pain in coccyx - .1 x 1 cm open area midline in coccyx area. cleansed, thin Tegasorb applied."	F 280			

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F 280	Continued From page 29 Interdisciplinary notes, dated 6/26/06, documented, "[resident] reported to CNA, "My butt hurts." On assessment there is a very small superficial open area high on the coccyx with a thin white rim around it. The entire area is slightly red." There was no description of the stage II pressure sore on admission. It could not be determined by record review if the pressure sore had been healed at any time during March, April, May and June 2006. The care plan, dated 4/4/06, indicated the resident had been identified as having an "alteration in skin integrity." An undated entry documented, "Air overlay," another care plan entry, dated 5/10/06, documented, "DC'd [air overlay] per resident request." Report any red or open areas, SAR [skin at risk] weekly on bath day. Skin breakdown will not progress from stage 1 to stage II in 30-90 days, Drsg [dressing] changes as ordered for pressure ulcer on coccyx..., position resident off of affected area on coccyx." The care plan goal indicated the resident's pressure sore was stage 1 and would not progress to stage II. The interdisciplinary, dated 5/10/06, documented the resident had a stage II pressure sore. That same day the air-overlay mattress was deleted on 5/10/06 per the resident's request. The care plan was not updated to accurately reflect the resident's current status.	F 280			

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F 281 SS=D	<p>483.20(k)(3)(i) COMPREHENSIVE CARE PLANS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observation and staff interview, it was determined the facility did not ensure physician orders were followed related to the application of ted hose. This was true for 1 of 15 sampled residents (#13). Findings include:</p> <p>Resident #13 was admitted to the facility on 5/5/06 with the diagnoses of pulmonary embolism, diabetes mellitus, congestive heart failure, cardiovascular disease, weakness, and an unspecified head injury.</p> <p>The resident's "Physician Recapitulation Orders" for June 2006, documented an order for "Bilateral knee high ted hose - on in AM/Off [at] HS [hour of sleep]. May use thigh high. Dx [diagnosis]: edema." The origination date of this order was 5/10/06.</p> <p>Resident #13 was observed on 6/28/06 at 12:05 pm and on 6/29/06 at 8:55 and 9:18 am. At each observation the resident did not have ted hose on either of her legs.</p> <p>On 6/29/06 at 11:50 am, the DON was interviewed related to ted hose not being on this resident. At that time she did not know why they were not on, but agreed to look into it and get back to the surveyor. At approximately 1:00 pm, the DON and a LN stopped the surveyor in the hall and indicated the resident did not have ted hose on because resident #13 would take them</p>	F 281	<p>F 281</p> <p>-RESIDENT #13 ORDER FOR TED HOSE WAS DISCONTINUED DURING SURVEY.</p> <p>-THIS PRACTICE COULD AFFECT ANY RESIDENT AND ALL STAFF WILL NOTIFY PHYSICIANS TIMELY WHEN AN ORDER WILL NOT BE FOLLOWED DUE TO RESIDENT NON-COMPLIANCE.</p> <p>-LICENSED STAFF WILL BE INSERVICED REGARDING NEED TO FOLLOW MD ORDERS AND GET ORDERS DISCONTINUED WHEN NEEDED.</p>		

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F 281	Continued From page 31 off as soon as they [the staff] put them on. Both acknowledged no one had informed the physician of the refusal to wear and that an order to discontinue the use of the ted hose was not obtained. The DON and LN acknowledged this refusal was not documented in the interdisciplinary notes or on the resident's care plan.	F 281	-RANDOM AUDITS BY DON TO ASSESS CURRENT ORDER ACCURACY. -COMPLETION 7/31/2006		
F 309 SS=D	483.25 QUALITY OF CARE Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and record review it was determined the facility did not maintain proper wheelchair positioning for 1 of 1 sample resident (#7), and did not provide necessary care related to a sore mouth and loose fitting dentures for 1 of 1 sample resident (#2). Findings include: 1. Resident #7 was admitted 5/27/04 with diagnoses that included post cerebral aneurysm rupture with significant infarct and resultant dysarthria and ataxia. The annual MDS assessment, dated 4/17/06, indicated the resident was independent in decision making and was totally dependent for ADL's. The assessment	F 309			

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F 309	Continued From page 32 indicated the resident had limitations of range of motion of the arms hands, legs and feet bilaterally. The care plan dated, 4/20/06 documented, "Has special seating system... observe for good body alignment and position for comfort." The following observations were made during the survey: On 6/26/06 at 10:50 am the resident was observed in a wheelchair by the bed sleeping. She was leaning sharply to the left with the top left of her body leaning over the wheel of the chair. On 6/26/06 at 7:30 am the resident was observed in the shower room in a shower chair. The CNA had just completed her bath. Two CNA's helped the resident stand, holding on to a grab bar in the shower area and transferred her into the wheelchair. She was leaning sharply to the left and that is how she was seated in the chair. She was not repositioned before leaving the bathing area On 6/27/06 at 9:30 am she was observed in activities leaning sharply to the left side in her wheelchair. On 6/27/06 at 12:15 pm prior to and during lunch in the dining room the resident was observed in her wheelchair. Her wheelchair had no lateral positioning devices. The resident's head and upper torso were leaning sharply to the left. At 12:25 pm, a CNA was asked about the special seating system the resident used. She stated she	F 309	F 309 -RESIDENT #7 WILL RECEIVE A NEW SEATING SYSTEM. THE WHEELCHAIR HAS BEEN ORDERED AND WHEN IT ARRIVES THE NEW SYSTEM WILL BE FITTED. RESIDENT #2 HAD HER DENTURES RELINED AND WENT TO HER MD FOR HER TONGUE WHICH WAS NOTED TO BE DRY -POSSIBLY FROM MEDICATION. -ROUTINE OBSERVATIONS ARE CARRIED OUT FOR ALL RESIDENTS BY STAFF. IF A PROBLEM ARISES IT WILL IS ASSESSED AND APPROPRIATE ACTION TAKEN. -THIS WILL BE COVERED IN THE MANDATORY LICENSED STAFF INSERVICE. -RANDOM ROUNDS BY UNIT MANAGERS AND DON FOR COMPLIANCE. -COMPLETION 7/31/2006		

Per phone conversation 8/4/06 to
adm & don. Res #7's w/c on
backorder. had Pt consult & have
positioning devices in place.

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F 309	<p>Continued From page 33</p> <p>had worked at the facility for a year and had never seen anything in the resident's wheel chair to help her sit upright. The CNA did not assist the resident to reposition prior to assisting her to eat. The resident shifted her position in an attempt to sit more erect as she ate.</p> <p>On 6/27/06 at 1:00 pm she was observed outside of the dining room in the hallway leaning sharply to the left in her wheelchair.</p> <p>On 6/27/06, at 8:50 am, during an interview, the physical therapist indicated a wheelchair was being modified for the resident, however it was a used chair and some parts needed repair. Before the chair was completed however, it had been decided the modified chair would not be appropriate for the resident. The resident liked to wheel her own chair and she would not be able to do so in the modified chair. He was not aware of any other positioning devices to assist the resident to maintain body alignment in the wheelchair. He stated he thought the resident had lateral supports in her wheelchair for positioning at one time but the supports caused skin problems under her arms from leaning to the left.</p> <p>On 6/27/06 at 1:30 pm the LN was asked about the resident's body alignment in her chair. She indicated staff did not use any supports to maintain position or change the resident from the wheelchair to a recliner to improve body alignment.</p>	F 309			
	<p>2. Resident #2 was admitted to the facility on 4/27/06 with diagnoses of Parkinson's disease and depression.</p>				

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F 309	<p>Continued From page 34</p> <p>The admission MDS, dated 5/09/06, indicated the resident was independent in decision making, needed extensive assistance to transfer and had an unsteady gait. The resident had a recent fall with abrasions and bruises. The assessment documented the resident had no chewing problems but was on a mechanically altered diet.</p> <p>The resident was observed on 6/26/06 at 2:55 pm. There were red cracked lines in the corner of her mouth. The resident stated her tongue had a burning feeling. The surveyor looked at her tongue, which was bright red and her dentures which were loose. The resident stated her tongue was sore and her dentures did not fit.</p> <p>On 6/27/06 at 7:45 am the resident's tongue was observed to be bright red and the dentures loose. The DON was interviewed by the surveyor who asked if staff were aware of the resident's sore red tongue. She stated she would check with the staff and resident. On 6/27/06 at 11:30 am the DON stated the resident had been eating raspberry jello which may have caused the tongue to be red. She stated the resident was going to the doctor in a few days.</p> <p>On 6/27/06 at 1:00 pm the social worker was interviewed regarding the resident's ill fitting dentures. He stated he was not aware of the problem. After this interview an appointment was made to evaluate the dentures.</p>	F 309			
	<p>The resident's record was reviewed. There was no documented assessment related to the resident's sore mouth or ill fitting dentures.</p>				

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F 309	Continued From page 35 On 6/29/06 at 10:30 am the DON provided a document from the physician indicating the resident's mouth was very dry and decreased the resident's Amitriptyline ordered for depression. The facility did not thoroughly assess a resident for ill fitting dentures and sore tongue.	F 309			
F 314 SS=G	483.25(c) PRESSURE SORES Based on the comprehensive assessment of a resident, the facility must ensure that a resident who enters the facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they were unavoidable; and a resident having pressure sores receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing. This REQUIREMENT is not met as evidenced by: Based on observations, staff interview and record review, it was determined the facility failed to ensure preventative measures were consistently implemented to prevent the development of pressure ulcers. This resulted in harm to resident #1 when she developed multiple recurring pressure areas on both of her heels. The facility also did not ensure pressure areas were adequately assessed and consistently documented. This effected 4 of 15 sampled residents (#s 1, 4, 10 and 13). Findings include: 1. Resident #1 was readmitted to the facility on	F 314			

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F 314	Continued From page 36 10/13/05 with the diagnoses of dementia, diabetes mellitus, cerebral vascular accident, chronic obstructive pulmonary disease, pneumonia, hypertension and osteoporosis. The resident's admission MDS, dated 10/25/05, documented the resident required extensive to total assistance of one to two staff for bed mobility, transfers, toileting, and personal hygiene. This assessment also indicated the resident was frequently to totally incontinent of bowel and bladder. Section M "Skin Condition" of this assessment indicated the resident had a stage I pressure ulcer. The resident's Pressure Ulcer RAP summary, dated 10/25/05, documented "RAP triggers due to pressure ulcer present, bowel continence and bed mobility...Resident has a pressure ulcer on her left heel..." The resident's two subsequent quarterly MDS assessments also indicated the resident was incontinent and required extensive to total assistance of staff for her activities of daily living. The resident's Initial Data Collection Tool/Nursing Service, dated 10/13/05 at 6:20 pm, documented under the "General Skin Condition" section that the resident had a "pressure sore" and that the heels were, "soft/mushy." The diagram noted an area on the left heel and a hand written comment of "soft mushy pink..." was documented. There was no description of size of the area in question on this form.	F 314	F 314 -RESIDENT #1 HAS WHEELCHAIR CUSHION AND MATTRESS THAT ARE PRESSURE REDUCING. SHE DOES NOT WEAR HER SHOES AT THIS TIME. THERE IS PROPER DOCUMENTATION FOR ALL WOUNDS AND CARE PLANS ARE CORRECT. SKIN CHECKS ARE OCCURRING WEEKLY AND ARE ACCURATE. RESIDENT #13 DOES NOT HAVE ANY WOUNDS AND DOES HAVE A WHEELCHAIR CUSHION AND MATTRESS THAT ARE PRESSURE REDUCING. AS DOES EVERY RESIDENT AT THIS FACILITY. RESIDENT #10 DOES NOT HAVE ANY WOUNDS ON HER COCCYX AND DID NOT DURING THE SURVEY. SHE DOES HAVE PRESSURE REDUCING MATTRESS AND PAD ON HER WHEELCHAIR. RESIDENT #4 DOES NOT WEAR HIS SHOES AT THIS TIME.		
	Resident #1's "Interim Care Plan," dated 10/14/05, listed the problem of, "Mobility Skin Breakdown." The approaches to this problem were, "Air overlay (hand written), Turn Schedule, SAR [skin at risk] q [every] week." This		-ALL RESIDENTS RECEIVE SKIN ASSESSMENTS WEEKLY OR MORE FREQUENTLY IF NEEDED TO IDENTIFY OTHER RESIDENTS WITH SKIN ISSUES.		

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F 314	Continued From page 37 temporary/interim care plan did not include the frequency of the turn schedule, nor was there any direction to float the resident's heels. This care plan also did not mention any assistive devices to keep pressure off the resident's heels which had a stage I upon admission to the facility. Resident #1 had a comprehensive care plan, dated 10/27/05, which documented a problem of "Alteration in skin integrity: resident has pressure ulcer and skin tears." The approaches for this problem included, "Air overlay over pressure relieving mattress, Apply heel and elbow guards as necessary, Edema checks Q day, Pressure relieving mattress on bed [and] cushion in w/c [wheelchair], Report any red or open areas, SAR checks weekly on bath day, dressing changes as ordered to pressure ulcer stage 1 on left heel." No additional documentation was found related to the pressure area on resident #1's left heel indicating the progress of the healing or when the area resolved. The resident's Interdisciplinary Progress Notes documented the following, on 12/19/05 at 11:45 am, "C/O [complains of pain] in rt [right] heel. Sm[all] black area [with] dry area on entire heel. Dressed [with] Allevyn/medipare for protection. On 12/21/05 at 2:00 pm, "Removed air overlay and placed raised-edge mattress. She is in a low bed also and will need a floor mat also."	F 314	-ALL STAFF WILL BE INSERVICED REGARDING THEIR RESPONSIBILITIES FOR CARE OF AND DOCUMENTATION OF SKIN ISSUES/CONCERNS. -RANDOM AUDITS OF RESIDENTS TO DETERMINE PROPER DOCUMENTATION, ASSESSMENT AND CARE PLANNING BY DON AND WOUND NURSE. -COMPLETION 7/31/2006 <i>Rev phone conversation 8/4/06 to adm & DON Res #4 is care plan addresses all care concerning feet & floating heels.</i>		
	A Physician's Telephone Order on 12/19/05, documented "Monitor Rt heel - Change protective dressing hydrasorb/medipore q 3 days [and] prn [as needed]. Protective blue boot on foot [at] all times."				

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F 314	<p>Continued From page 38</p> <p>There was no additional documentation found in the Interdisciplinary Progress Notes related to the area on the right heel until 1/18/06 were it was documented, "...She has no skin issues at this time. The right heel has healed..."</p> <p>There was no documentation found indicating the resident's care plan was updated to reflect the "protective blue boot" that was to be on the right heel "at all times." There was also no documentation found that indicated the staff was directed to float the resident's heels or to provide pressure relief of the resident's heels especially after the air overlay mattress was discontinued on 12/21/05.</p> <p>The resident's most current Braden Scale assessment, dated 4/23/06, documented the resident was a high risk for development with a score of "11."</p> <p>The resident's most current care plan, dated 4/13/06, documented the following related to skin integrity approaches, "Apply heel and elbow guards as necessary, FYI [for your information]: will not leave on, Pressure relieving mattress on bed [and] cushion in w/c, report any red or open areas, SAR checks weekly on bath day..."</p> <p>On 6/15/06, the resident's Interdisciplinary Progress Notes contained an entry that documented, "(Callous) Left heel [with] area that is open. Entire area 1.5 x [by] 1 cm [centimeters] raw appearing - Center 0.6 x 0.3 cm open/scabbed area.</p> <p>A facsimile was found to the resident's physician,</p>	F 314			

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F 314	<p>Continued From page 39</p> <p>dated 6/15/06, which documented "Open area on lt [left] heel. 1.5 x 1 cm [with] open area 0.6 x 0.3. [no] drainage. May we clean [with] wound cleanser [and] cover [with] hydrosorb [and] Mefix tape q d [day] till healed. Also may we give MVI [multivitamin] - Vit C 500 mg [milligram] BID [twice a day] [and] Zinc 220 mg q d to promote wound healing?" They physician responded on 6/19/06 and indicated, "yes" to the above request.</p> <p>The resident's care plan documented an update on 6/15/06 under the skin integrity section and indicated, "left heel open area - (old callous) see tx [treatment] sheet." This care plan update did not indicate the resident was to have the heels floated or any other special device to the foot/heel applied.</p> <p>Resident #1's Interdisciplinary Progress Notes documented the following after identifying the wound;</p> <p>*6/16/06, "...puff boots in place while in bed."</p> <p>*6/18/06, "...dressings changed on lt forearm [and] lt heel. No s/s [signs or symptoms] of infection. Puff boot in place when in bed.</p> <p>*6/19/06, "...Left heel dressing [changed] [with] hydroabsorb [after] being cleaned [with] ns [normal saline]. Area about 1/2 cm in diameter. Puff boot in place on [left] lower extremity..."</p> <p>*6/22/06, "Calloused area on L outer heel is dry and not open. There is a dark spot in the middle which is a dry scabbed area. She is using a puffboat {sic} while in bed and on Vit C [and] Zinc [and] MVI. Skin protocol in process and area is looking better. The [illegible word] isn't draining or red or mushy or painful."</p> <p>*6/29/06, "Left outer heel [with] 0.6 x 0.4 cm open area [with] black tissue in center. Outer area</p>	F 314			

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F 314	<p>Continued From page 40</p> <p>surrounding open area -hard callus- [not] red. Spongy heel left [and] right."</p> <p>Resident #1's treatment sheet for June 2006 was reviewed. This form had an area to document the Skin at Risk checks that were to be done weekly. This form directed staff to document "(+) = no problem / (-) = problem, Note problem on back of sheet." There was an area to document on 6/19 and 6/26/06. Both areas documented a "(+)" indicating no skin problems. The back of this form had an area with a picture to document where any skin problems would be as well as an area for measurements, visual description of the problem area, and any comments. There were two entries for the month and were as follows;</p> <p>*6/23/06, "pt [patient] won't leave on Geri Gloves or wear boot."</p> <p>*6/26/06, "coccyx red - R elbow red from hitting on w/c arm."</p> <p>There was no documentation of a pressure ulcer on the left heel which was discovered on 6/15/06. There was also mention of a red area on the coccyx, which was not identified in the interdisciplinary notes. The entry on 6/26/06 on the back of the treatment sheet mentioning a red area on the coccyx did not include size dimensions or a thorough description of the area.</p> <p>The following observations of resident #1 were made during the survey:</p>	F 314			
	<p>On 6/26/06 at 2:15 pm, resident #1 was observed lying in bed. She had a air type boot on the left foot, but nothing on her right foot. There was no cushion in her wheelchair. The resident was on a</p>				

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F 314	<p>Continued From page 41</p> <p>low bed with a lip mattress. This mattress was not an air bed or an air overlay. It appeared to be a regular mattress.</p> <p>On 6/27/06 at 8:38 am, resident #1 was observed sitting in her wheelchair out by the nurse's station. There was no cushion observed in her wheelchair and she was wearing shoes. At 11:17 am, resident #1 was observed lying in bed. She had on an air type boot on her left foot/heel, but her right foot was in a diabetic type shoe with her heel on the bed.</p> <p>On 6/28/06 at 6:45 am, resident #1 was observed sitting in her wheelchair. The resident did not have a pressure reducing device in her chair. The resident had shoes on both feet.</p> <p>On 6/28/06 at 1:30 pm, the DON was asked to provide documentation of the heel wounds for resident #1 upon admission, on 12/19/06 and the most current on 6/15/06. The only treatment sheets provided was the one for June 2006. Otherwise there was no additional documentation provided related to the identification, assessment and treatment for resident #1's heels.</p> <p>On 6/29/06 at 9:29 am, resident #1 was observed in her wheelchair sitting by the nurse's station. There was no pressure relieving device in her wheelchair. The resident was wearing diabetic shoes on both feet.</p> <p>On 6/29/06 at 9:45 am the surveyor observed the dressing change on the resident. The resident was lying on her left side in her bed and her floating air boot was on the bedside table. The wound nurse removed the sock from the</p>	F 314			

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F 314	Continued From page 42 resident's left foot and removed the dressing. A pressure ulcer was observed on the lateral aspect of the left heel. The ulcer was 0.6 cm (centimeters) x 0.4 cm with a blackened area in the center which made up about one-half of the entire ulcer. The area around the blackened spot was very hard and calloused. The wound nurse cleansed the area with saline, applied skin barrier and then applied, Allevyn, a non-adhesive dressing. Above this area was another area that was about 1.5 cm x 1.5 cm, and was soft, mushy, and reddened. The floating air boot was then put on the foot. The wound nurse then checked the right heel. There was a soft, mushy area about 2 cm x 2 cm that was very reddened. The nurse stated that this area would require close and constant observation as it was also breaking down. She then asked the hall nurse to be sure to get another floating air boot for the right heel. On 6/29/06 at 11:10 am the unit manager was interviewed. She acknowledged that the resident was supposed to have a pressure relieving device in her wheelchair but indicated the one they had for the resident caused some positioning concerns at times. The unit manager indicated they were working on getting her one that worked better. On 6/29/06 at 11:50 am, the DON was interviewed and acknowledged the inconsistent documentation of resident #1's pressure areas on her heels. She acknowledged the treatment sheets should have documented a (-) and listed a better description of the problem on the designated days. The DON was informed of the resident not having a pressure relieving device in her bed or wheelchair during survey. The DON	F 314			

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F 314	Continued From page 43 did not know if the resident's lip mattress was pressure relieving or reducing but though it was at least a reduction in pressure. The DON was asked to provide the manufactures information related to pressure reduction for that specific mattress. No information was provided. The facility failed to implement preventative measures for resident #1 who was admitted at a high risk for pressure ulcer development. The resident was admitted with impaired skin on her heel and the facility did not direct staff to relieve pressure off the heels. The resident developed a pressure area on the right heel on 12/29/05. The resident's physician indicated blue boots to be on at all times, but this direction did not appear on the resident's care plan. Resident #1 developed another pressure area on the left heel on 6/15/06 and a air puff boot was put in place on that heel, but nothing was put in place for the right heel. During an observation by a surveyor, the facility's wound nurse identified that the right heel was getting ready to break down as well. Resident #1 was harmed when the facility failed to prevent multiple avoidable pressure areas to resident #1's heels. 2. Resident #13 was admitted to the facility on 5/5/06 with the diagnoses of pulmonary embolism, diabetes mellitus, congestive heart failure, cardiovascular disease, weakness, and an unspecified head injury. The resident's admission MDS, dated 5/16/06, indicated the resident required limited to total assistance of one staff for bed mobility, transfers, toileting and personal hygiene and was frequently incontinent of bladder. This assessment also indicated that at the time of the assessment, the resident had a	F 314			

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F 314	<p>Continued From page 44</p> <p>stage I pressure ulcer. The resident's Pressure Ulcer RAP summary, dated 5/16/06, documented, "RAP triggers due to pressure ulcer present and bed mobility...Resident has a reddened pressure area on her coccyx area..."</p> <p>The resident's comprehensive care plan, dated 5/9/06, documented the following as an approach to prevent skin breakdown, "pressure relieving mattress on bed [and] cushion in w/c."</p> <p>On 6/28/06 at 12:05 pm, resident #13 was observed lying in bed. The resident's mattress was not an air bed nor an air overlay. The mattress appeared to be a regular mattress and not pressure relieving. The resident's wheelchair was observed and there was no cushion present. The resident was observed again on 6/29/06 at 8:55 am sitting in her wheelchair. There was no pressure relieving or reducing device in her chair. At 9:18 am, the resident was observed in bed and again no pressure relieving device was found on the bed and no cushion was in the resident's wheelchair.</p> <p>On 6/29/06 at 11:50 am, the DON was informed of the observations of no pressure reducing cushion in the resident's wheelchair. The DON was not sure why there was no cushion and would look into the matter. No additional information was provided.</p> <p>The facility did not ensure a resident who had a stage I area on her coccyx on admission received a pressure relieving device in her bed or wheelchair to prevent further breakdown.</p>	F 314			

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F 314	Continued From page 45 3. Resident #10 was admitted to the facility on 3/22/06 with peripheral vascular disease [PVD], left below knee amputation and status post cerebrovascular accident [CVA]. The "Braden Scale for Predicting Pressure Sore Risk," dated 3/22/06, indicated the resident was at high risk for the development of pressure ulcers with a total score of 12. The initial MDS, dated 3/26/06, documented the resident had a stage II pressure sore. The RAPs, dated 3/31/06, documented the resident was receiving treatment for a pressure sore. The most current quarterly MDS, dated 6/26/06, documented the resident had a stage II pressure sore. The care plan, dated 4/4/06, indicated the resident had been identified as having an "alteration in skin integrity." An undated entry documented, "Air overlay," another care plan entry, dated 5/10/06, documented, "DC'd [air overlay] per resident request." Report any red or open areas, SAR [skin at risk] weekly on bath day. Skin breakdown will not progress from stage 1 to stage II in 30-90 days, Drsg [dressing] changes as ordered for pressure ulcer on coccyx..., position resident off of affected area on coccyx." The onset date of the pressure sore was not documented on the care plan. The treatment sheet for the weekly skin at risk checks were not completed consistently, i.e., during the time period of 3/22- 4/30/06 there were no skin checks documented.	F 314			

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F 314	Continued From page 46 Interdisciplinary notes, dated 3/27/06, documented, "Res [resident] c/o [complained] pain in "tail bone", "butt" region while sitting in the wheelchair during therapy. She stated, 'You cannot believe how bad my butt hurts to sit in this chair.' Nsg [nursing] notified so can assess." There was no assessment located in the record. Interdisciplinary notes, dated 4/6/06, documented, "Admitted with stage II, is healing." There was no description of the wound. Interdisciplinary notes, dated 5/10/06 at 10:40 am, documented, "[resident] requests the air overlay be removed, coccyx wound in healing stage." That same day at 9:00 pm a note documented, "c/o of pain in coccyx - .1 x 1 cm open area midline in coccyx area. cleansed, thin Tegasorb applied." Treatment orders, dated 6/9/06, included, "Skin at risk, check 1 time a week [+] no problem, [-] problem, note problem on back of sheet." Tegaderm, apply to open area on coccyx, change q [every] three days & prn [as necessary], check area daily." Interdisciplinary notes, dated 6/26/06, documented, "[resident] reported to CNA, "My butt hurts." On assessment there is a very small superficial open area high on the coccyx with a thin white rim around it. The entire area is slightly red." The LN and Don were interviewed on 6/28/06 at approximately 11:40 am. neither of the nurses	F 314			

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F 314	Continued From page 47 knew if the resident had a pressure sore at the present time. On 6/28/06 at approximately 12:40 pm the resident was observed to have a stage II pressure sore on the coccyx. There was no description of the stage II pressure sore on admission. It could not be determined by record review how many times the pressure sore had been healed and then reopened. The CMS [Center for Medicare and Medicaid Services] guidelines for F314 stated, "It is important that the facility have a system in place to assure that the protocols for daily monitoring and for periodic documentation of measurements, terminology, frequency of assessment, and documentation are implemented consistently throughout the facility. When a pressure ulcer is present, daily monitoring, (with accompanying documentation, when a complication or change is identified),...With each dressing change or at least weekly (and more often when indicated by wound complications or changes in wound characteristics), an evaluation of the pressure ulcer wound should be documented. At a minimum, documentation should include the date observed and: Location and staging; Size..., depth; and...undermining or tunneling/sinus tract; Exudate...; Pain...; Wound bed...; Description of wound edges and surrounding tissue..."	F 314			
	4. Resident # 4 was admitted to the facility on 10/10/03 with diagnoses that included diabetes type 1 and above knee amputation of right leg due to osteomyelitis. The annual MDS				

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F 314	<p>Continued From page 48</p> <p>assessment dated 9/28/05 indicated the resident was totally dependent with two+ persons physical assist for transfer, dressing and toilet use and needed extensive assistance of one person for bed mobility. The MDS documented the resident had edema and two Stage I pressure ulcers. The most recent quarterly MDS assessment, dated 4/2/06, recorded the same status as above.</p> <p>The Care Plan dated 4/02/06, included the following:</p> <p>a) "Problem: Alteration in mobility... Approach(s) - Assist to reposition. Turn q 2 hr [hour] in bed. Pressure alarm in bed due to dementia with impulsivity. Self-release seat belt alarm in w/c [wheelchair]. Raised edge mattress in bed. Sabina Lift [set to stand]."</p> <p>b) "Problem: Potential for alteration in skin integrity...Approach(s) - Weekly skin assessment on bath day. 1 person assist to reposition q 2 hr...pressure reducing mattress on bed and pad in w/c. Total assist with incont[inence] management...puff-boot to LLE [left lower extremity] in bed to reduce pressure and shearing of LT [left] heel, Ted hose, no shoes.</p> <p>On 6/26/06 at 2:00 pm, resident #4 was observed in bed. He was on his back and his eyes were closed. He was covered with a small quilt. His mattress was observed to be a concave lip mattress with no pressure relief. His left foot was not visible to the surveyor.</p> <p>On 6/26/06 at 3:00 pm, the resident was observed in bed, his eyes were closed. His left leg was bent at the knee and his foot was resting on the surface of the bed. His quilt was slightly hanging off the right side of the bed allowing</p>	F 314			

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F 314	<p>Continued From page 49</p> <p>visibility of his left foot. He was observed wearing a light non-pressure relieving blue puff boot on his left foot.</p> <p>On 6/28/06 at 6:03 am, during the resident's morning cares he was observed wearing the soft puff boot on his left foot. After cares he was transferred to his wheelchair and the CNA put on a black shoe. When asked about the shoe the CNA indicated he wore a diabetic shoe when he was up in his wheelchair.</p> <p>Accompanied by the wound nurse, the surveyor observed the resident's left foot on 6/29/06 at approximately 1:00 pm. The resident's left foot was examined by the wound nurse. A quarter sized mushy area was observed on his left internal (medial) heel located over the calcaneus. There were three nickle sized blanchable dark red areas on the right lateral aspect of the left foot. There were no open areas.</p> <p>On 6/29/06 at approximately 2:00 pm, during an interview with the South A Care Coordinator, she acknowledged that resident #4 had been fitted with a diabetic shoe in April 2006. Documentation from the company was presented to the surveyor for review.</p> <p>Although the resident had been fitted for a diabetic shoe in April 2006 the care plan was not updated to reflect the new shoe. There were no interventions documented in the care plan to direct the staff on the care of the resident's foot to prevent the development of pressure ulcers. (i.e. check shoe for proper fit, check for foot edema that might be caused by the shoe and long periods of being in a dependent position, how</p>	F 314			

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F 314	Continued From page 50 long was he allowed to have his leg and foot in a dependent position, how long he was to wear the shoe, and when to off load pressure on his heel.)	F 314			
F 323 SS=D	483.25(h)(1) ACCIDENTS The facility must ensure that the resident environment remains as free of accident hazards as is possible. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, it was determined the facility did not ensure staff transferred resident's safely using mechanical lifts. This was true for 1 of 7 sampled residents (#1) transferred by a mechanical lift. Findings include: Resident # 1 was readmitted to the facility on 10/13/05 with the diagnoses of dementia, diabetes mellitus, cerebral vascular accident, chronic obstructive pulmonary disease, pneumonia, hypertension and osteoporosis. The resident's admission and two most recent quarterly MDS assessments, dated 10/25/05, 1/24/06, and 4/24/06, all documented the resident required total assistance of two staff for transfers. Resident #1's last "Physical Therapy Weekly Summary," dated 11/16/05, documented the resident was "dependent" for transfers, requiring "two person" support. This form also documented, "...With no return in L [left] UE [upper extremity] or LE [lower extremity] and limited trunk control when upright, see mech	F 323			

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F 323	Continued From page 51 [mechanical] lift as the only safe method to transfer this resident for staff...ensure staff is aware of safe transfer method for this resident." The resident's Comprehensive Care Plan, dated 4/13/06, documented "Mechanical lift for transfers or two person transfer at times." The care plan was not specific as to the type of mechanical lift to use and how many staff members were needed to use the lift. On 6/27/06 at 11:17 am, one CNA entered the resident's room with a sit to stand lift. The CNA helped the resident get into an upright position on the edge of the bed. Resident #1 had a great deal of difficulty remaining upright without the staff assistance. The CNA placed the trunk support strap around the resident and guided the resident's legs down to the platform for the feet. On the lift there was a place to secure the resident's legs to the lift with a strap. The CNA did not secure the resident's legs. Resident #1 was not able to hold on to the provided grab bars with her left hand due to functional loss. The CNA raised the lift and the resident was suspended in the lift holding on with her right arm and the trunk strap fastened. The resident's legs were not secure and looked as if they could give out at any point. The CNA moved the lift over to the resident's wheelchair and began trying to guide the resident in the lift over to the chair. However, the CNA did not lock the wheelchair wheels and the wheelchair was moving about. The CNA was then trying to guide the resident in the lift and stabilize the wheelchair at the same time. All the while the resident was hanging on with one hand and her legs not secure in the lift. The CNA finally got the wheelchair secure and the resident was	F 323	F323 -STAFF INVOLVED IN THIS TRANSFER HAS BEEN RE-INSERVICED IN THE PROPER USE OF ALL LIFTS. -ALL RESIDENTS WHO USE A MECHANICAL LIFT HAVE THE POTENTIAL TO BE AFFECTED BY THIS PRACTICE. -ALL NURSING STAFF WILL BE INSERVICED IN THE PROPER USE OF ALL MECHANICAL LIFTS -SDC WILL RANDOMLY SHADOW CNA'S TO ASSESS CURRENT PRACTICE FOR PROPER USE. -COMPLETION 7/31/2006	

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F 323	<p>Continued From page 52</p> <p>lowered into the wheelchair without incident. The inappropriate transfer technique observed by the surveyor put the resident at risk for possible injury.</p> <p>On 6/28/06 at 1:30 pm, the DON and administrator were asked to provide policy and procedure for use of mechanical lifts. The facility did not have a policy and procedure for use of mechanical lifts. They were then asked to provide the manufactures recommendations for use of the lifts and the DON indicated that the lifts come with a video and they instruct staff how to use the lift by the video. The DON and administrator were asked if there was any written information that came with the lift directing people on how to safely operate the lifts. The DON indicated that maybe the staff development person had that information and would look into it. No additional information was provided.</p> <p>On 6/29/06 at 11:50 am, the DON was informed of the observation of the unsafe transfer of resident #1. The DON acknowledged the CNA should have secured the legs of the resident with the provided strap and should have locked the resident's wheelchair. The DON indicated they like to have two people in with all mechanical lift transfers to ensure the safety of the residents. However, she indicated that if the transfer is done right, the sit to stand lift is designed to be used by one staff member. The DON indicated that it seemed the CNA needed to view the instructional video again before using the lift.</p>	F 323			

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F 325 SS=D	<p>483.25(i)(1) NUTRITION</p> <p>Based on a resident's comprehensive assessment, the facility must ensure that a resident maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review and staff interview, it was determined the facility did not ensure that specific interventions identified by the interdisciplinary team (for example: snacks passed and follow up by the registered dietitian) were consistently implemented to prevent weight loss and/or promote weight gain. This was true for 3 or 15 sampled residents (#'s 1, 5, and 8).</p> <p>1. Resident #1 was readmitted to the facility on 10/13/05 with the diagnoses of dementia, diabetes mellitus, cerebral vascular accident, chronic obstructive pulmonary disease, pneumonia, hypertension and osteoporosis. The resident's admission and two most recent quarterly MDS assessments, dated 10/25/05, documented the resident required extensive to total assistance of one staff for eating.</p> <p>Review of the resident's "Weight Record" indicated that upon readmission to the facility the resident weighted 140.6 pounds. The resident's weight dropped to 121.8 on 6/5/06. This was a decrease of 13.4% since admission (8 months).</p> <p>Resident #1 was followed closely by the interdisciplinary Nutrition At Risk (NAR) committee. On 2/23, 3/9 and 4/6/06, the NAR</p>	F 325	<p>F 325</p> <p>-RESIDENTS #1,5,8 ARE HAVING COMPLETE DOCUMENTATION OF SNACKS.</p> <p>RESIDENT #8 WAS DOCUMENTED ON BY THE RD DURING SURVEY AND WILL REVIEW MONTHLY UNTIL STABLE.</p> <p>-ALL RESIDENTS RECEIVING SNACKS HAVE THE POTENTIAL TO BE AFFECTED. DIETARY WILL PROVIDE RD WITH WRITTEN COMMUNICATION REGARDING NEED TO DOCUMENT MONTHLY ON ALL RESIDENTS MOVED FROM NAR (NUTRITION AT RISK) TO RD CHARTING</p> <p>-ALL NURSING STAFF WILL BE INSERVICED REGARDING EXPECTED DOCUMENTATION OF SNACKS AND MEALS.</p> <p>-RANDOM AUDITS BY DIETARY AND NURSING.</p> <p>-COMPLETION DATE 7/31/2006.</p>		

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F 325	<p>Continued From page 54</p> <p>committee recommended "snacks TID [three times a day]." On 4/20/06, the NAR committee recommended to "D/C [discontinue] HS [hour of sleep or bedtime] sn [snack] 2° [secondary] to refusals." The NAR committee then recommended "snacks BID [twice a day]" on 5/1, 5/18, 6/8 and 6/22/06.</p> <p>Resident #1's Meal Monitor sheets for February, March, April, and May 2006 were reviewed. There were three areas (10 am, 3 pm and HS) to document snacks.</p> <p>*In February, there were three 3 pm snacks documented and 2 HS snacks documented. There was no indication that the snacks were refused at any time.</p> <p>*In March, no 3 pm snacks were documented, and only 1 HS snack was documented. There was no indication that the snacks were refused.</p> <p>*In April, there were two 3 pm snacks documented and no HS snacks documented. There was one indication that a 3 pm snack was refused. The other days, there was no indication that the missing snack documentation was due to resident refusal.</p> <p>*In May, there was no 3 pm snacks documented. There was no indication that the missing snack documentation was related to resident refusal.</p> <p>On 6/29/06 at approximately 10:15 am, the facility's registered dietitian (RD) was interviewed. She acknowledged that implementation of snacks was a intervention to prevent further weight loss for this resident. The RD also acknowledged that</p>	F 325			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 135110	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 06/30/2006
NAME OF PROVIDER OR SUPPLIER KARCHER ESTATES			STREET ADDRESS, CITY, STATE, ZIP CODE 1127 CALDWELL BLVD NAMPA, ID 83651		
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F 325	<p>Continued From page 55</p> <p>the 3 pm and HS snack for this resident was consistently not documented. The RD agreed the lack of this documentation impacts the assessment of interventions to prevent weight loss. When asked how the HS snack was discontinued due to refusal when they were never documented, the RD indicated that they had to ask staff if the resident refused. The RD voiced frustration with the documentation of the snacks and agreed it was a problem area.</p> <p>Resident #1 had multiple urinary tract infections and some other acute illnesses during this time. This resident also had very little intake and could make her needs known when she wanted to stop eating or had enough. The weight loss this resident experienced was unavoidable, but the facility's lack of documentation of care planned interventions hindered the accurate assessment of implemented interventions to prevent further weight loss.</p> <p>2. Resident #8 was admitted to the facility on 11/12/02 with the diagnoses of dementia, right bundle branch block, cardiovascular disease, hypothyroidism, and depression. The resident's most recent quarterly MDS, dated 4/13/06, documented the resident was severely cognitively impaired and was totally dependent on one to two staff for all activities of daily living including eating.</p> <p>Review of the resident's "Weight Record" indicated that on 1/16/06 the resident weighed 113.8 pounds. The resident's weight dropped to 98.4 pounds on 6/14/06. This was a decrease of 13.5% in 5 months.</p>	F 325			

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F 325	<p>Continued From page 56</p> <p>Resident #8 was followed closely by the interdisciplinary Nutrition At Risk (NAR) committee. On 2/23, 3/9, 3/23, 4/6/06, the NAR committee recommended "snacks BID [twice a day]." On 4/20/06, the NAR committee recommended to "D/C HS sn 2° to refusals." The NAR committee then recommended "snacks 10 am shake" on 5/18 and 6/8/06.</p> <p>Resident #8's Meal Monitor sheets for February, March, April, and May 2006 were reviewed. There were three areas (10 am, 3 pm and HS) to document snacks.</p> <p>*In February, there were four 3 pm snacks documented and no HS snacks documented. There was no indication that the snacks were refused at any time.</p> <p>*In March, no 3 pm or HS snacks documented. There was no indication that the snacks were refused.</p> <p>*In April, there were no snacks documented. For three days at 3 pm, it was documented the resident refused the afternoon snack. The other days, there was no indication that the missing snack documentation was due to resident refusal.</p> <p>In May, only 10 am snacks were documented, however this was the month when the other snack had been discontinued.</p>	F 325			
	<p>3. Resident #5 was admitted to the facility 12/12/00 with diagnoses that included senile dementia, convulsions, cerebral aneurysm with right hemiparesis dominant side and depressive disorder. The most recent quarterly MDS</p>				

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F 325	<p>Continued From page 57</p> <p>assessment dated 6/26/06, indicated she needed supervision of one staff for eating.</p> <p>A Nutritional Risk Review dated 1/31/06, indicated the resident had a significant weight loss over the last 30 days. It was noted the resident had been ill with pneumonia and was experiencing poor intake. Recommendation of the interdisciplinary team included enhanced meals, weekly weights, offer shakes for snacks TID [three times a day] and review in 1 week</p> <p>The care plan dated 4/6/06, documented under alteration in nutritional status: "Offer snacks TID."</p> <p>The February 2006 meal monitors contained an area to document snacks in spaces corresponding with the day of the month, directed the staff to document % and initial. The 3:00 pm, snack was documented on the 10th and 11th day as 100% consumed and refused on the 20th. All other spaces were blank. The HS [hour of sleep] snack was documented on the 1st as refused, on the 10th and 11th as 100% consumed and refused on th 14th. All other spaces were blank. The March 2006 meal monitors also contained an area to document snacks. All spaces were blank.</p> <p>The Nutrition Risk Review Progress Note dated 3/9/06 documented, "DC [discharge] for RD [registered dietitian] cont[inue] [with] interventions. The Nutrition Progress Notes were blank.</p>	F 325			
	<p>During an interview with the RD on 6/29/06 at approximately 1:00 pm, she acknowledged she dropped the ball and had not follow up with the resident's progress.</p>				

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F 441 SS=E	<p>483.65(a) INFECTION CONTROL</p> <p>The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment and to prevent the development and transmission of disease and infection. The facility must establish an infection control program under which it investigates, controls, and prevents infections in the facility; decides what procedures, such as isolation should be applied to an individual resident; and maintains a record of incidents and corrective actions related to infections.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interview the facility failed to provide a sanitary environment to prevent the development and transmission of disease and infection for 1 of 5 sampled residents (#7) who resided on the 'B' hall. Findings include:</p> <p>On 6/26/06 at 7:50 am, Resident #7 was observed showering in a bathing area. The following observations were made:</p> <p>a. Resident #7 was observed during a shower. Several items of clothing were observed on the bathroom floor. The CNA confirmed the clothing on the floor belonged to Resident #7. After the shower was completed the CNA took the resident's clean clothing from the floor i.e., slacks, blouse, bra, and socks and dressed the resident.</p> <p>b. Resident supplies i.e., hair curlers, makeup, combs and hairnets were observed in the facility bathing area on "B" hall. These items were not labeled for individual residents. There were 14 bottles of shampoo labeled with resident's names</p>	F 441	<p>F 441</p> <p>-RESIDENT #7 HAS HAD CLEAN CLOTHING SINCE SURVEY.</p> <p>ALL RESIDENT SUPPLIES ARE LABELED FOR INDIVIDUAL RESIDENTS. BASINS HAVE BEEN DISPOSED OF AND TOWELS WILL BE PUT ON A COVERED CART. (CART HAS BEEN ORDERED).</p> <p>-BOTH SHOWER ROOMS WILL HAVE NEEDED CARTS AND SPACE TO STORE NEEDED SUPPLIES.</p> <p>-RANDOM ROUNDS WILL BE DONE BY SDC.</p> <p>-COMPLETION 7/31/2006</p> <p><i>Per phone conversation = adm done. 8/4/06. Covered cart has not arrived. towels placed in a drawer/drawer. Staff was instructed</i></p>		

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F 441	Continued From page 59 in the shower stall. The CNA was interviewed at that time. She stated the resident's shampoo was routinely stored in the bathing area, where multiple residents were bathed, instead of storing the resident personal items in their rooms. Labeled and unlabeled personal care items stored in a multi use area pose a risk for comingling of resident items and the risk of transmitting infection. c. Three plastic, pinkish/tan colored bath basins were observed stored in the dressing area outside the shower on the floor. d. Four folded white bath towels were observed uncovered on a bench in the bathing area used by multiple residents, posing a risk of contamination.	F 441			
F 444 SS=D	483.65(b)(3) PREVENTING SPREAD OF INFECTION The facility must require staff to wash their hands after each direct resident contact for which handwashing is indicated by accepted professional practice. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview, it was determined the facility did not ensure staff members washed their hands after direct resident contact in order to prevent/control the possible spread of infections. This was true for 1 of 15 sampled residents (#8). Findings include:	F 444			

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F 444	<p>Continued From page 60</p> <p>On 6/27/06 at 1:22 pm, resident #8 was assisted to bed by 2 CNAs. CNA 1 brought in a Hoyer type mechanical lift. CNA 1 and CNA 2 helped position the lift sling under the resident, touching the resident's clothes and Geri Chair. CNA 1 operated the lift and CNA 2 guided the resident into the bed. CNA 1 and CNA 2 rolled the resident to the right and left to remove the lift sling. Both CNA 1 and CNA 2 handled the resident's clothing and the resident, positioning the resident with pillows. CNA 1 also handled the resident's call light and bed controls. CNA 1 then took the lift to the door, opened the door and went to a room across the hall and entered the room. CNA 1 was observed to push the lift over to the far bed and begin setting it up to transfer the resident in the far bed. CNA 2 washed her hands and headed over to the room where CNA 1 was to assist in the transfer. CNA 1 was never observed to wash her hands after she had direct contact with a resident before leaving the resident's room and going to assist another resident.</p> <p>On 6/28/06 at 1:30 pm, the DON and administrator were informed of the observation of lack of handwashing. Both agreed the CNA should have washed her hands before leaving the room and before touching the lift to use on another resident.</p>	F 444	<p>F 444</p> <p>-EMPLOYEE IDENTIFIED IN THIS TAG USED HAND SANITIZER AFTER CARES TO THIS RESIDENT AND PRIOR TO GIVING CARES TO THE NEXT RESIDENT. SHE STATED THAT SHE PULLED THE SANITIZER OUT OF HER POCKET AS SHE WAS LEAVING THE ROOM-WITH HER BACK TO THE SURVEYOR</p> <p>-ALL STAFF WILL BE INSERVICED REGARDING PROPER USE OF SANITIZER AND PROPER HANDWASHING.</p> <p>-RANDOM OBSERVATION AND ROUNDS WILL BE DONE BY SDC AND DON.</p> <p>-COMPLETION 7/31/2006</p>		

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F 445 SS=E	<p>483.65(c) INFECTION CONTROL - LINENS</p> <p>Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff did not handle and store soiled linens to prevent spread of infection. This had the potential to affect all residents on the "B" hallway. The findings include:</p> <p>On 6/26/06 at 7:50 am, soiled wash cloths, resident gowns and bath towels (a 2 foot by 5 foot high stack), was observed on the floor against the wall in the bathing area. A CNA, working in the room at that time, stated there was not enough space in the bathing area for a hamper. The Administrator and DON were interviewed on 6/26/06 at 8:15 am. Both stated they were unaware a hamper was not being used for storing soiled linen.</p>	F 445	<p>F 445</p> <p>-NO LINEN HAS BEEN PUT ON THE FLOOR SINCE OBSERVED DURING SURVEY.</p> <p>-A HAMPER HAS BEEN ORDERED FOR THE SHOWER ROOM FOR DIRTY LINEN.</p> <p>-ALL STAFF WILL BE INSERVICED REGARDING NOT PUTTING LINEN/TOWELS ON FLOOR.</p> <p>-RANDOM ROUNDS IN SHOWER/RESIDENT ROOMS BY SDC, DON</p> <p>-COMPLETION 7/31/2006</p> <p><i>Per phone conversation 8/4/06 to admin & Don. hamper has not arrived using a cart on wheels. Staff instructed</i></p>		

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C 000	<p>INITIAL COMMENTS</p> <p>The Administrative Rules of the Idaho Department of Health and Welfare, Skilled Nursing and Intermediate Care Facilities are found in IDAPA 16, Title 03, Chapter 2.</p> <p>The following deficiencies were cited during the annual State licensure survey of your facility.</p> <p>The surveyors conducting the survey were:</p> <p>Kari Head, RD, MS Betty Vivian, RN, MSN Diane Green, RN Winnie Young, RN</p> <p>Survey Definitions: MDS = Minimum Data Set assessment RAP = Resident Assessment Protocol RAI = Resident Assessment Instrument DON = Director of Nursing LN = Licensed Nurse CNA = Certified Nurse Aide ADL = Activities of Daily Living MAR = Medication Administration Record</p>	C 000	<p>RECEIVED</p> <p>JUL 31 2006</p> <p>FACILITY STANDARDS</p>		
C 125	<p>02.100,03,c,ix</p> <p>ix. Is treated with consideration, respect and full recognition of his dignity and individuality, including privacy in treatment and in care for his personal needs;</p> <p>This Rule is not met as evidenced by:</p>	C 125	<p>See F241</p>		
C 175	<p>02.100,12,f</p> <p>f. Immediate investigation of the</p>	C 175			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

Anna L. Lant

TITLE
Executive Director
(X6) DATE
7/31/06

6899

WG9J11

If continuation sheet 1 of 5

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C 175	Continued From page 1 cause of the incident or accident shall be instituted by the facility administrator and any corrective measures indicated shall be adopted. This Rule is not met as evidenced by: Refer to F 225 as it relates to the failure to investigate accidents.	C 175	See F 225		
C 361	02.108,07 HOUSEKEEPING SERVICES AND EQUIPMENT 07. Housekeeping Services and Equipment. Sufficient housekeeping and maintenance personnel and equipment shall be provided to maintain the interior and exterior of the facility in a safe, clean, orderly and attractive manner. This Rule is not met as evidenced by: Refer to F 253 as it relates to the failure to maintain an clean and sanitary environment.	C 361	See F 253		
C 650	02.150,01,a,vii vii. Resident care practices, i.e., catheter care, dressings, decubitus care, isolation procedures. This Rule is not met as evidenced by: Refer to F441 as it relates to the failure to ensure care is provided to prevent the transmission of disease.	C 650	See F 441		
C.671	02.150,03,b b. Proper handling of dressings, linens and food, etc., by staff. This Rule is not met as evidenced by: Refer to F445 as it relates to the failure to ensure linen was handled to prevent the spread of	C.671	See F 445		

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C 671	Continued From page 2 infection.	C 671			
C 758	02.200,02,a,ii ii. The D.N.S. in facilities with an average occupancy rate of fifty-nine (59) patients/residents or less may, in addition to administrative responsibilities, serve as the supervising nurse. This Rule is not met as evidenced by: Based on record review and staff interview it was determined the facility failed to provide a full 8 hours of RN coverage for the following shifts: Days 6/4/06 - 7.50 hours 6/5/06 - 7.50 " 6/8/06 - 7.60 " 6/13/06 - 7:55 " 6/18/06 - 7:50 " 6/20/06 - 7:19 " 6/24/06 - 7:62 " Evenings 6/4/06 - 7.50 hours 6/5/06 - 7.50 " 6/8/06 - 7.50 " 6/9/06 - 7.50 " 6/10/06 - 7.54 " 6/12/06 - 6.99 " 6/13/06 - 7.50 " 6/15/06 - 7.50 " 6/16/06 - 7.50 " 6/17/06 - 7.50 " 6/18/06 - 7.82 " 6/20/06 - 7:93 " 6/21/06 - 7.83 " 6/22/06 - 7.50 " 6/24/06 - 7.50 "	C 758	C 758 -FACILITY WILL MAKE EVERY EFFORT TO HAVE 8 HOURS OF RN COVERAGE ON A DAILY BASIS WHEN OUR CENSUS IS 59 OR BELOW	7/31/06 LH	

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C 758	Continued From page 3 This is a total of 22 shifts with less then 8 hours of RN coverage during the 3 weeks reviewed. There were also 7 nights when the facility failed to provide a full 8 hours of a LN coverage on the night shift during the 3 weeks reviewed. During an interview with the DON on 6/28/06 at approximately 11:00 am, she acknowledged the facility required all staff to stay on the premises during lunch and be available to work if needed.	C 758			
C 782	02.200,03,a,iv iv. Reviewed and revised as needed to reflect the current needs of patients/residents and current goals to be accomplished; This Rule is not met as evidenced by: Refer to F280 as it relates to the failure to revise care plans.	C 782	<i>See F286</i>		
C 784	02.200,03,b b. Patient/resident needs shall be recognized by nursing staff and nursing services shall be provided to assure that each patient/resident receives care necessary to meet his total needs. Care shall include, but is not limited to: This Rule is not met as evidenced by: Refer to F309 as it relates to the facility's failure to provide necessary care and services.	C 784		<i>See F 309</i>	
C 787	02.200,03,b,iii iii. Adequate fluid and nutritional	C 787			

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C 787	Continued From page 4 intake, including provisions for self-help eating devices as needed; This Rule is not met as evidenced by: Refer to F 325 as it relates to the failure to provide nutritional support as needed.	C 787	<i>See F325</i>		
C 789	02.200,03,b,v v. Prevention of decubitus ulcers or deformities or treatment thereof, if needed, including, but not limited to, changing position every two (2) hours when confined to bed or wheelchair and opportunity for exercise to promote circulation; This Rule is not met as evidenced by: Refer to F314 as it relates to the failure to provide care to prevent pressure sores.	C 789			